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LONG-TERM CARE SUPPORTS AND SERVICES
ADVISORY COMMISSION
September 24, 2007

LONG-TERM CARE SUPPORTS & SERVICES
ADVISORY COMMISSION
EXECUTIVE COMMITTEE
SEPTEMBER 10, 2007
MINUTES

ATTENDEES: RoAnne Chaney, Chris Chesny, Jane Church, Andy Farmer, Michael Head, Gloria Lanum, Jon Reardon, Jackie Tichnell, Hollis Turnham

September Commission Meeting in Detroit – Agenda will consist of standing items – no special presentations planned. Time will be allotted to react to the morning testimony. Budget will be discussed during both the Chair's report and the Director's report. If there is no resolution on the budget there will be a need to help Commissioners understand the impact of a government shut-down. Head agreed to keep Commission informed as he learns more and will include a general discussion of budget during his director's report. He will check with the DCH Director regarding the State's budget message. It was suggested that each Commissioner should have his/her own press release regarding the budget and be prepared to discuss how delayed action is affecting their constituency. Farmer will include such a request in the cover memo sent with this month's information packet.

Agenda will also include updates from Commissioners on their workgroup activities. These are not expected to be written reports but rather verbal updates.

Turnham suggested a special invitation be sent to the Detroit media so they are aware that the input session and meeting are being held in Detroit. Church indicated the department is

working on a press release that is scheduled to be issued on 9/17.

Public Input Session: Chaney will provide a 20-30 minute overview of the LTC Task Force recommendations at the beginning of the session after which public comment will be taken. Room is being set up for 150 people. The Office will bring a portable sound system, computer, and projector.

Church and Farmer will follow-up with DLTCC on housekeeping details (press table, cameras, room set-up, accessibility issues for wheelchair users, etc.).

The Detroit LTC Connections will provide lunch for those Commissioners who come to the morning public input session and stay for the LTC Commission meeting. Farmer will include a request in his cover memo for Commissioners to RSVP to Jackie Tichnell if they intend to eat lunch with the group.

Estate Recovery - there is progress to report. This will be a part of the September agenda.

SPE – Follow-up presentations by SPEs will be provided at November meeting. The Office should have more Service Point data by then, and will have a sense for how well SPEs are doing with level of care determinations. Commission is interested in actions taken to increase consumer participation. Contract language for 2008 includes a requirement that 1/3 of the governing and advisory board membership be consumers. It was agreed that the Commission will formulate questions in advance that each SPE will report back on.

OFFICE OF LONG-TERM CARE SUPPORTS & SERVICES
Long-Term Care Supports and Services Advisory Commission
Update, September 25, 2007

1. Long-Term Care Connections (LTCC) Projects – a report of activity is attached
   a. Evaluation - The Information and Assistance consumer survey is being pilot tested with the assistance of our evaluation contractor, the Michigan Public Health Institute (MPHI.)

   b. Mandatory Level of Care – Beginning November 1, 2007, for persons who reside within a LTCC area, the required functional Level-of-Care (LOC) determination required under the Medicaid program to approve Medicaid payment for nursing facility or MI Choice Waiver care will be conducted by the LTCC, rather than the provider of services. This change is authorized in a Medical Services Administration (MSA) policy promulgated and issued on September 1. This change is required under PA 634 of 2006. Much developmental work has been conducted over the summer and especially during September to assure LTCC capacity and responsiveness to this requirement.

   c. Budgets have been finalized and contracts provided and signed for each of the four LTCC for FY 2008.

2. System Transformation Grant Project
   a. CMS is accepting of our plan to retain a Project Director for this five year grant project. The position is approved and is awaiting posting, which will not occur until after the budget for FY 08 is resolved.

b. The evaluation design for the project was submitted to CMS in August, after additional stakeholder review and comment.

3. Long-Term Care Insurance Partnership program – See handout

4. MI Choice Waiver Renewal
    a. CMS has approved the MI Choice Waiver Program renewal application for the five-year period October 1, 2007 through September 30, 2012.

    b. The Specialized Residential Licensed Setting subcommittee continues to meet to examine the implications of placing into the MI Choice waiver a covered service option that will pay for special licensed residential settings (Adult Foster Care and Homes for the Aged).

5. Prepaid LTC Health Plan pilot project
    a. The feasibility study for this project is being developed by MSA's contractor Health Management Associates.

    b. Workgroups are being formed to develop the details for a submission of the requisite Waiver applications.

    c. Consultations with the Wisconsin Department of Health & Family Services are being conducted to further refine our knowledge and understanding of their Family Care Program.

d. The Department's application to the Center for Health Care Strategies to participate in their Managed Long Term Supports and Services Purchasing Institute was approved, allowing the Department to be part of a multi-state network of health care officials looking at these sorts of programs.

6. Deficit Reduction Act - Money Follows the Person grant
    a. Funds are built into the budget for FY 08 to implement this project.

    b. CMS has made it clear that it will not entertain Michigan's proposed Operational Protocol required under the grant until the Department has retained a full-time civil servant Project Coordinator.

    c. The position posting for this Coordinator was posted for internal fill only, this week.

    d. The Pathway Workgroup continues to meet to develop this document, which will be the central part of our Operational Protocol, which is required by CMS.

    e. A data workgroup has been meeting to define the data elements required by the grant and identify data sources for these elements.

7. Self-Determination in Long-Term Care – see handout

8. Person-Centered Planning Practice Guideline
    a. The Person-Centered Planning for Community Based Long-Term Care: Practice Guidance for the MI Choice Waiver Sites document has been through final revisions

and will be finalized and issued by the end of September 2007. .

b. We are awaiting word (expected this week) on whether the Person-Centered Planning grant application made to CMS in July is awarded. There is much competition from other states. The grant would assist with future training in PCP methods, including the development of cadres of independent facilitators.

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BILL ANALYSIS

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Senate Bill 511 (Substitute S-1)
Sponsor: Senator Ron Jelinek
Committee: Appropriations

Date Completed: 9-23-07

CONTENT

Senate Bill 511 (S-1) makes fiscal year (FY) 2007-08 appropriations for the Executive branch, the Judiciary, the Legislative branch, community colleges, and universities. The bill, combined with the FY 2007-08 School Aid Fund appropriations contained in Senate Bill 237 (S-1), would provide for $42.6 billion of Gross appropriations, $9.5 billion of General Fund/General Purpose (GF/GP) appropriations, and the appropriation of 55,153.9 full-time equated positions. Table 1 provides a summary of the Gross appropriations, GF/GP appropriations, and full-time equated positions contained in the bill by State department or budget area. Table 2 provides a comparison of the GF/GP appropriations in Senate Bill 511 (S-1) with the current services level of FY 2007-08 GF/GP appropriations. Current services appropriations are defined as a continuation of the FY 2006-07 appropriation levels adjusted for cost increases, funding delays, and caseload adjustments. The FY 2007-08 GF/GP appropriations in the bill are $587.5 million below the current services funding level.

Table 3 provides a summary of the FY 2007-08 GF/GP estimates of revenue, expenditures, and year-end balances if Senate Bill 511 (S-1) is enacted into law and no additional revenue increases are enacted. The revenue numbers in the table assume that the State utilizes the $219.4 million of one-time revenue that are estimated to be received from the Michigan Business Tax and that the level of statutory revenue sharing paid to cities, villages, and townships paid in FY 2007-08 is the same as the appropriated level in FY 2006-07. Comparing these FY 2007-08 GF/GP revenue assumptions with the GF/GP appropriations contained in Senate Bill 511 (S-1) leads to a projected budget deficit of $568.8 million. If Senate Bill 511 (S-1) is enacted into law, the Governor and the Legislature will have to take additional actions to eliminate this projected budget deficit.

The following information provides a department-by-department description of the highlights of the line-item appropriations in Senate Bill 511 (S-1). The information provides a summary of the reductions contained in the bill from the current services appropriation levels.

Department of Agriculture: The bill represents a $5.1 million GF/GP reduction from the current services appropriation level. Major reductions include $1.7 million from Executive Division, $0.9 million from the Pesticide and Plant Management Division, and $2.5 million from Environmental Stewardship. The bill also includes the elimination of GF/GP funding for local conservation districts, Export Marketing Program, and the Cervid Culture Program.

Attorney General: The bill represents a $7.6 million GF/GP reduction from the current services appropriation level. The reduction was attained through a departmental negative appropriation of $7.5 million. Since the budget is primarily driven by direct employee costs, the reduction could result in the elimination of approximately 107 employees or 19.0% of the departmental work force.

Department of Civil Rights: The bill represents a $1.8 million GF/GP reduction from the current services appropriation level. The reduction was attained through a departmental negative appropriation of $0.9 million and $0.9 million of reductions in departmental economic increases. Since this budget is primarily driven by direct employee costs, the reductions could result in the elimination of approximately 25 employees or 18.0% of the departmental workforce.

Department of Civil Service: The bill represents a $2.7 million GF/GP reduction from the current services appropriation level. The reduction was attained through a $2.5 million departmental negative appropriation and a $0.2 million reduction in departmental economic increases. Since this budget is primarily driven by direct employee costs, the reductions could result in the elimination of approximately 38 employees or 16.0% of the departmental workforce.

Community Colleges: The bill represents a $7.1 million GF/GP reduction from the current services appropriation level. The reduction is based on the elimination of the 2.5% funding increase which is assumed in the current services funding level. The bill includes the $25.8 million of funding to repay the funding delay that was instituted in FY 2006-07. The bill will leave overall community college appropriations at the initial FY 2006-07 appropriated levels.

Department of Community Health: The bill represents a $116.8 million GF/GP reduction from the current services appropriation level. Major reductions include $25.6 million from the elimination of Medicaid coverage for caretaker relatives, $12.7 million from the elimination of Medicaid coverage for 19- and 20-year olds, $5.2 million from the elimination of multicultural grants to mental health providers, $18.9 million from the elimination of a majority of Healthy Michigan-funded grant programs, $18.0 million from revised caseload estimates in concurrence with the House Fiscal Agency and the State Budget Office, $10.0 million of savings from mandated citizenship verification for Medicaid recipients, $9.3 million from various other Medicaid and departmental changes, and $15.0 million from a 1.1% provider rate reduction for all nonmanaged care Medicaid providers.

Department of Corrections: The bill represents a $111.2 million GF/GP reduction from the current services appropriation level. Major reductions include $37.5 million from removing funding for currently vacant department positions, $55.0 million from bed reductions across the system including the closure of the Southern Michigan Correctional Facility, the closure of the Egeler Reception and Guidance Center Annex, the closure of the Riverside Correctional Facility, and the re-opening of the Michigan Reformatory; $10.0 million from cuts to nonholiday overtime pay; $3.7 million from the partial-year savings resulting from the centralization of prison store operations; $6.9 million from savings in prison food services; and $8.8 million from various staffing efficiencies. The bill also includes $18.3 million of new funding for 1,520 additional beds at various correctional facilities. These additional beds would be adding an eighth bed in seven-bunk open bays.

Department of Education: The bill represents a $3.5 million GF/GP reduction from the current services appropriation level. Major reductions include $1.0 million from the State Board and State Superintendents Office, $0.8 million from departmental central support functions, $0.8 million from School Finance and School Law programs, $0.4 million from Career and Technical Education programs, $0.3 million from information technology programs, and $0.2 million from Early Childhood and Family Services. The impact of the reductions across the Department will lead to the layoffs of approximately 44 employees.

Department of Environmental Quality: The bill represents a $7.9 million GF/GP reduction from the current services appropriation level. Major reductions include $5.7 million from the reduction of 143 employee positions across the Department and $2.3 million from a GF/GP reduction to the Drinking Water Loan Fund. This employee reduction represents a 9.0%

reduction for the Department. The reduction to the Drinking Water Loan Fund will also result in a loss of $9.2 million of Federal funds.

Executive Office: The bill represents a $0.2 million GF/GP reduction from the current services appropriation level. The reduction was attained through a $52,700 departmental negative appropriation and reductions in economic funding.

Higher Education: The bill represents a $35.9 million GF/GP reduction from the current services appropriation level. The reduction is based on the elimination of the 2.5% funding increase which is assumed in the current services funding level. The bill includes the $138.7 million of funding to repay the funding delay that was instituted in FY 2006-07. The bill will leave overall Higher Education appropriations at the year-to-date FY 2006-07 appropriated levels, which include the reductions in Public Act 17 of 2007.

Department of History, Arts, and Libraries: The bill represents a $6.9 million reduction from the current services appropriation level. Major reductions include a $6.2 million reduction in State aid to libraries and $0.4 million from book distribution centers.

Department of Human Services: The bill represents a $207.5 million reduction from the current services appropriation level. The major reductions include $47.2 million from changes in day care reimbursement rates, $35.4 million from caseload costs adjustments, $57.1 million from Family Independence program sanctions, $18.1 million from departmental budgetary savings, $11.8 million from the closure of the Maxey Boys Training School, $13.5 million from changes in child welfare programs, $6.1 million from day care case reviews, and $18.3 million of other savings from various program reductions and funding shifts. The closure of the Maxey Boys Training School will result in the layoff of 268 employees.

Judiciary: The bill represents a $7.6 million GF/GP reduction from the current services appropriation level. The reduction was spread proportionally across all line items containing GF/GP appropriations, excluding judicial salaries. The reduction could result in the loss of up to 59 employees or approximately 11.0% of the judicial workforce.

Labor and Economic Growth: The bill represents a $9.6 million GF/GP reduction from the current services appropriation level. Major reductions include $2.6 million in Fire Protection grants, $4.4 million in workforce training grants, $1.7 million in welfare-to-work programs, $0.3 million from Focus Hope program funding, and $0.2 million from administrative programs.

Legislative Auditor General: The bill represents a $1.4 million GF/GP reduction from the current services appropriation level. Since this budget is primarily driven by direct employee costs, the reductions could result in the elimination of approximately 31 employees.

Legislature: The bill represents a $7.4 million GF/GP reduction from the current services appropriation level. The reduction included $4.4 million of undesignated legislative reductions and $3.0 million in reductions in economic adjustments for all legislative agencies.

Department of Management and Budget: The bill represents a $2.1 million GF/GP reduction from the current services appropriation level. The reductions include $0.6 million in departmental undesignated reduction and a $1.5 million in reduction in economic adjustments.

Department of Military and Veterans Affairs: The bill represents a $2.2 million GF/GP reduction from the current services appropriation level. The reductions include $1.6 million from grants to veterans' service organizations and $0.6 million in other administrative reductions.

Department of Natural Resources: The bill represents a $1.1 million GF/GP reduction from the current services appropriation level. The reduction was taken from purchased land payments in lieu of taxes. The Department would have to prorate payments to local units of government that it distributes for land it owns within each jurisdiction. The reduction would also reduce the amount of restricted funds distributed since State law requires that the General Fund pay for at least 50.0% of the total.

Secretary of State: The bill represents a $14.0 million GF/GP reduction from the current services appropriation level. The reductions include $13.1 million of undesignated departmental reductions and a $0.9 million reduction in economic adjustments. The reduction could result in the closure of approximately 25 branch offices and the layoff of approximately 80 employees.

Department of State Police: The bill represents a $14.1 million GF/GP reduction from the current services appropriation level. The reductions include $8.3 million from a 59.0% reduction in Secondary Road Patrol grants, $4.8 million from Justice Training Fund grants, and $1.0 million in other administrative reductions.

Strategic Fund Agency: The bill represents a $2.1 million GF/GP reduction from the current services appropriation level. The major reduction is a $2.6 million fund shift in the funding of the Michigan Promotion program. Funding for a portion of the Michigan Promotion Program will be shifted to funds received back to the Department as a result of pay-backs on loans and other returns on investments from the previous Life Science and Technology Tri-Corridor programs. The bill includes a $100 placeholder for funding of a new Entrepreneurial Training and Mentoring program.

Transportation: The bill includes two transfers of State Restricted transportation revenue to the GF/GP budget. The first is a $5.0 million transfer of Comprehensive Transportation Fund revenue. This reduction is taken from local bus operating grants, $2.5 million; intercity passenger and freight rail programs, $1.45 million; administrative functions, $0.8 million; and the transportation to work program, $0.3 million. The second transfer is $13.0 million from the Economic Development Fund. This reduction is taken from targeted industries, $6.5 million; urban county congestion, $3.25 million; and rural county primary, $3.25 million.

Treasury-Operations: The bill represents an $11.6 million GF/GP reduction from the current services appropriation level. The reductions included $10.2 million of undesignated departmental reductions and $1.4 million of other reductions spread across the Department. The reductions could result in the layoffs of approximately 137 employees.

Treasury-Revenue Sharing: The bill provides for a freeze in revenue sharing payments to cities, villages, and townships. Some local units will receive increases in the overall level of revenue sharing payments if they are only receiving constitutional revenue sharing payments.

Departmental Boilerplate Language: Senate Bill 511 (S-1) contains complete boilerplate intent language for each department and appropriation. The boilerplate in the bill generally conforms to the boilerplate in the Senate-passed versions of the individual appropriation bills for each department and program.

Fiscal Analyst: Gary S. Olson

Table 1

Senate Bills 511 (S-1) and 237 (S-1)
Full-Time Equated Positions (FTEs), Gross,
and General Fund/General Purpose Appropriations

Department/Budget Area	FTEs	Gross Appropriations	GF/GP Appropriations
Agriculture	652.0	$101,814,300	$25,168,400
Attorney General	556.0	62,079,400	25,362,100
Civil Rights	136.0	13,106,400	11,052,300
Civil Service	240.5	34,338,100	4,161,300
Community Colleges	na	316,039,200	316,039,200
Community Health	4,651.0	11,625,177,800	3,060,970,400
Corrections	17,340.5	2,022,458,400	1,940,360,800
Education	416.6	93,321,600	3,714,600
Environmental Quality	1,561.7	357,915,100	24,632,400
Executive Office	74.2	5,252,900	5,252,900
Higher Education	1.0	1,880,545,300	1,747,345,300
History, Arts, and Libraries	228.0	43,555,100	33,350,500
Human Services	9,248.5	4,430,617,900	1,185,402,200
Information Technology	1,774.4	406,193,400	0
Judiciary	519.0	253,472,600	152,177,800
Labor and Economic Growth	4,277.5	1,285,028,700	40,029,800
Legislative Auditor General	0.0	14,665,700	11,324,300
Legislature	0.0	108,215,900	106,706,100
Management and Budget	747.5	472,471,000	265,508,600
Military and Veterans Affairs	1,015.0	128,221,900	39,177,700
Natural Resources	2,082.9	288,567,900	23,249,900
School Aid[1)]	0.0	12,814,269,900	35,000,000
State	1,853.8	194,041,900	15,507,700
State Police	2,899.0	554,966,100	275,330,600
Strategic Fund Agency	152.0	164,352,000	28,123,300
Transportation	3,029.3	3,360,255,600	0
Treasury	1,697.5	1,533,294,600	138,674,900
Total	**55,153.9**	**$42,564,238,700**	**$9,513,623,100**

[1)] The School Aid appropriations are contained in Senate Bill 237 (S-1). The remaining appropriations are contained in Senate Bill 511 (S-1).

Table 2

Senate Bill 511 (S-1)
General Fund/General Purpose Reductions

Department/Budget Area	FY 2007-08 Current Services Budget	GF/GP Reductions	Restricted Revenue Reductions	Total GF/GP or Equivalent Reductions
Agriculture	$30,316,000	$(5,147,600)		$(5,147,600)
Attorney General	32,858,100	(7,496,000)		(7,496,000)
Civil Rights	12,812,200	(1,759,900)		(1,759,900)
Civil Service	6,815,200	(2,653,900)		(2,653,900)
Community Colleges	323,128,800	(7,089,600)		(7,089,600)
Community Health	3,177,794,500	(116,824,100)		(116,824,100)
Corrections	2,051,684,500	(111,323,700)		(111,323,700)
Education	7,164,100	(3,449,500)		(3,449,500)
Environmental Quality	32,577,500	(7,945,100)		(7,945,100)
Executive Office	5,453,600	(200,700)		(200,700)
Higher Education	1,783,275,700	(35,930,400)		(35,930,400)
History, Arts, & Libraries	40,299,500	(6,949,000)		(6,949,000)
Human Services	1,392,931,700	(207,529,500)		(207,529,500)
Judiciary	159,740,200	(7,562,400)		(7,562,400)
Labor & Economic Growth	47,182,300	(7,152,500)	$(2,410,500)	(9,563,000)
Legislative Auditor General	12,681,000	(1,356,700)		(1,356,700)
Legislature	114,088,800	(7,382,700)		(7,382,700)
Management & Budget	267,617,600	(2,109,000)		(2,109,000)
Military & Veterans Affairs	41,422,100	(2,244,400)		(2,244,400)
Natural Resources	24,352,000	(1,102,100)		(1,102,100)
School Aid	35,000,000	0		0
State	29,535,600	(14,027,900)		(14,027,900)
State Police	276,739,800	(1,409,200)	(12,712,600)	(14,121,800)
Strategic Fund Agency	30,249,600	(2,126,300)		(2,126,300)
Transportation	0	0		0
Treasury	150,251,300	(11,576,400)		(11,576,400)
Total	**$10,085,971,700**	**$(572,348,600)**	**$(15,123,100)**	**$(587,471,700)**

Table 3

FY 2007-08 Senate Bill 511 (S-1) Budget Summary General Fund/General Purpose (millions of dollars)	
Revenue:	
Consensus Revenue Estimate (May 2007).....	$6,919.7
Michigan Business Tax (Ongoing Revenue)	1,189.5
Michigan Business Tax (One-Time Revenue)	219.4
Revenue Sharing Freeze.....	558.3
Restricted Revenue Transferred to General Fund (S.B. 511 (S-1))	15.1
Comprehensive Transportation Fund Transfer (S.B. 511 (S-1))	5.0
Other Revenue Adjustments	37.8[a)]
**Total Current Services Revenue.....	**$8,944.8**
Expenditures:	
Senate Bill 511 (S-1) and Senate Bill 237 (S-1).....	$9,513.6
**Projected FY 2007-08 Budget Imbalance	**$(568.8)**

a) Includes $2.0 million from a financial institution fund transfer, $22.8 million from the School Aid Fund for short-term State borrowing costs, and $13.0 million transfer from the Transportation Economic Development Fund.

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SELF-DETERMINATION IN LONG-TERM CARE
Office of Long Term Care Supports and Services
Michigan Department of Community Health

Michigan's initiative to assure opportunities for consumer self-determination in the MI Choice program has been developed over the past two and one-half years using a grant from the Robert Wood Johnson Foundation's Cash & Counseling National Program office, awarded in October 2004. Self Determination in Long Term Care, Michigan's title for its initiative, is based on the "Cash and Counseling" model of service delivery. Cash and Counseling expansion projects are being funded by RWJF in ten states at this time. Three states; Arkansas, New Jersey and Florida, were pilot states for this project. RWJF also funds the National Program Office for Cash and Counseling who oversee the projects in the states, and provide training, technical assistance and resources to each project. For more information, go to: http://www.cashandcounseling.org/

The funding provided supports a state-level Project Coordinator, and assistance to four MI Choice Waiver "Pioneer" sites to support a local project coordinator. Since April 2005, the state-level project coordinator has worked with these four local coordinators to develop the methods and policy guidance that supports these participant-directed service options. As well, the state coordinator has been involved in developing, in partnership with the Waiver operations unit in the Medical Services Administration, necessary amendments to the MI Choice Waiver to allow certain services to be directly controlled by the waiver program participants. To date, there are 100 participants who are enrolled in the initiative and who are managing an individual budget and directly employing and managing their personal assistance workers. In FY 2008, the option for offering arrangements that support self-determination for MI Choice Waiver program participants is to be expanded across the remaining 17 MI Choice Waiver Program entities.

The Self-Determination in Long-Term Care initiative works for individual MI Choice Waiver program participants in this way:

1. A MI Choice participant who has been informed of this option may request to become a participant in service arrangements directly controlled and directed by the participant.
2. A review of the individual's plan of services is conducted using a person-centered planning process, and necessary service arrangements are confirmed/reconfirmed. The plan is costed out and an individual budget is developed from the plan of services and the costs associated with the plan.
3. Once agreement is reached on the plan and the individual budget, the individual and the MI Choice Waiver Agent entity sign a Self-Determination Agreement, outlining the roles and responsibilities of the Waiver program entity and the participant.
4. The individual budget is controlled and directed by the participant so that they may select, employ and compensate the participant's direct service workers. However, funds comprising the individual budget are not provided to the participant. Instead, they are lodged in a qualified independent entity called a fiscal intermediary.
5. The fiscal intermediary works with the program participant to handle deployment of the funds in the individual budget so that they are able to be applied with increased flexibility and control by the participant. The fiscal intermediary is responsible for numerous tasks related to employer responsibilities, such as: background checks, payroll and related taxes and monthly reports on spending to participant and waiver agent. Fiscal intermediaries submit to a rigorous review process in order to qualify as a provider.

6. The fiscal intermediary also performs a fiscal management role for agency funds for services on behalf of the MI Choice Waiver agent entity, providing monthly reports of individual budget use to the Waiver agent, and to the participant. Fiscal intermediaries are required to be bonded and to carry insurance for the amount of their budgetary liability for MI Choice Waiver funds.
7. Once things are in place, the participant may select, interview and select the personal assistance workers required to provide their authorized waiver services.
8. Participant control and direction is assured via the direct employment arrangement and also through the authority provided to the participant to directly negotiate wages, hours and working conditions. In particular, worker scheduling provides greater opportunity for the participant to obtain direct support in varying amounts based upon how their lives may require this assistance, within an overall monthly allotment.
9. Funds not deployed in a consumer's individual budget may be authorized for the consumer to purchase "goods & services" which are items or services which would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment, and are not available through other means. Only participants in self-determination may access the goods and services option and then only with available or perhaps projected savings from their individual budget.

To date, the Self-Determination in Long-Term Care initiative has been extremely well-received by those who have chosen this option. The four MI Choice Waiver Agent entities participating as "Pioneer" sites are: Tri-county Office on Aging (Lansing area), Detroit Area Agency on Aging, UPCAP Services (Upper Peninsula) and Burnham Brook (Battle Creek area). Each Pioneer site dedicates one full time equivalent to coordinate the project on the local level. Each Pioneer Site was awarded $75,000 over two years and matched that with $25,000 of their funding to cover the cost of the position. The state project coordinator, Ms. Tari Muñiz, works through the Office of Long-Term Care Supports & Services.

<u>As of September 7, 2007</u>:

* 100 Participants have enrolled in Self Determination in Long Term Care

* Special training in person-centered planning has been provided to the Pioneer sites.

* The majority of workers hired are family members; this program frequently allows them to leave other jobs in order to take care of their loved ones.

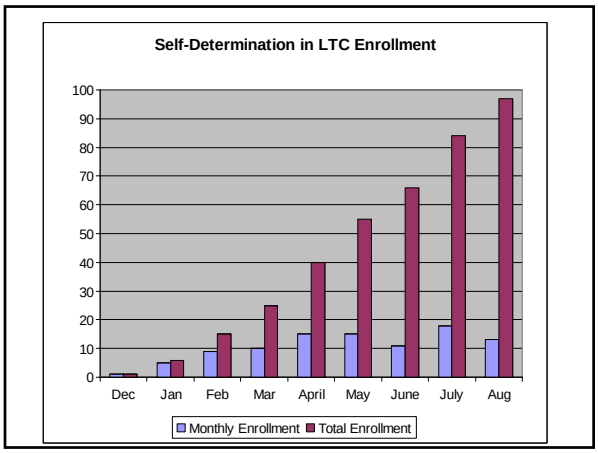
* The costs of services for participants of Self Determination have not exceeded the costs of their services through traditional waiver service options.

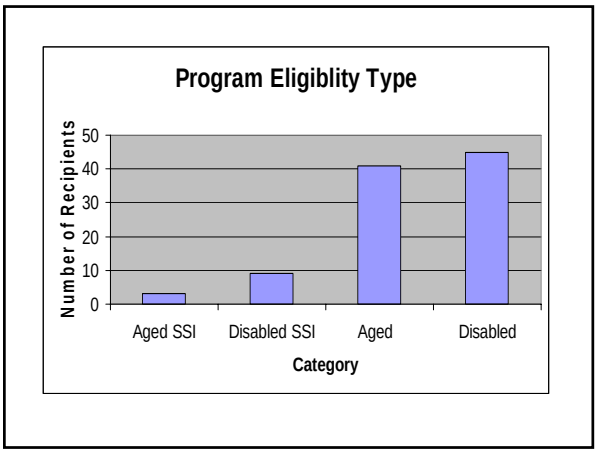
* Quality measuring instruments for the participants are being developed to measure both quality of life and satisfaction with services.

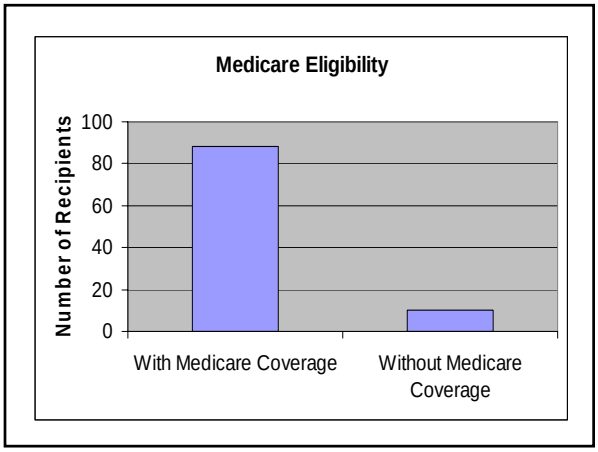
* Training began in summer 2007 with the other 17 waiver sites to prepare for statewide implementation.

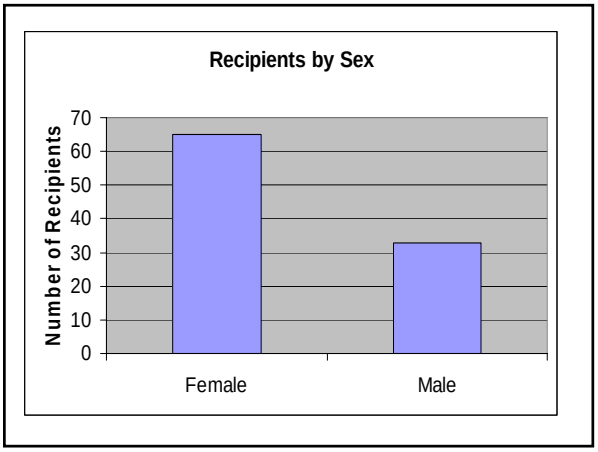
* Statewide implementation will be phased in throughout fiscal year 2008.

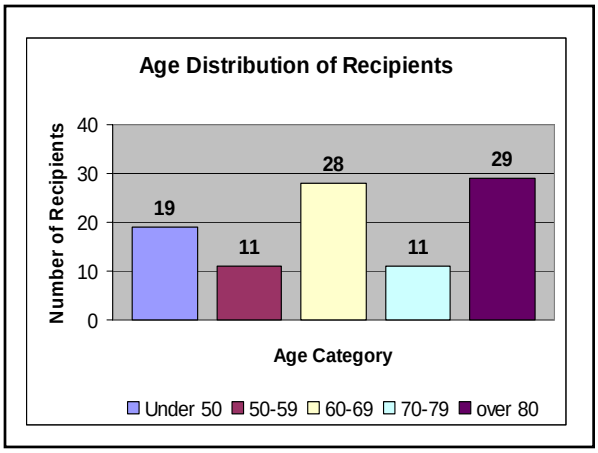
September 2007

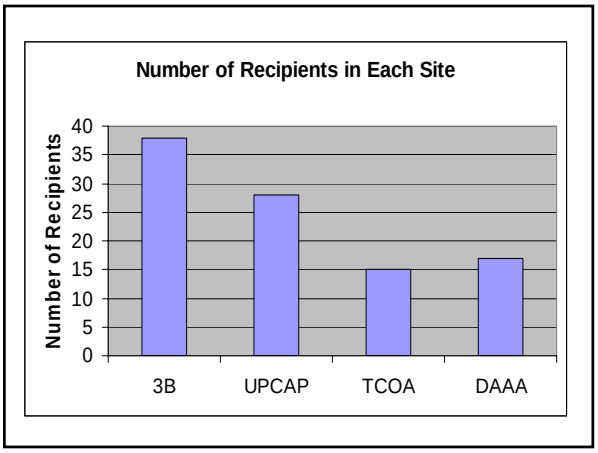

Self-Determination in LTC Enrollment
100
90
80
70
60
50
40
30
20
10
0
Dec
Jan
Feb
Mar
April
May
June
July
Aug
Monthly Enrollment
Total Enrollment


Program Eligiblity Type
Number of Recipients
50
40
30
20
10
0
Aged SSI
Disabled SSI
Aged
Disabled
Category


Medicare Eligibility
Number of Recipients
100
80
60
40
20
0
With Medicare Coverage
Without Medicare Coverage


Recipients by Sex
Number of Recipients
70
60
50
40
30
20
10
0
Female
Male


Age Distribution of Recipients
Number of Recipients
40
30
20
10
0
19
11
28
11
29
Age Category
Under 50
50-59
60-69
70-79
over 80


Number of Recipients in Each Site
Number of Recipients
40
35
30
25
20
15
10
5
0
3B
UPCAP
TCOA
DAAA

SELF-DETERMINATION IN LONG-TERM CARE
Stories

MF - is a 34 year old female, with Traumatic Brain Injury. She was very dissatisfied with the agency and the workers that were coming 2 days per week (She was approved for daily care, but the agency could never find staff to fill all the hours) The agency would change her staff, send them at odd hours, and change her days of care. The agency also would not allow the workers to "become friends" with MF and therefore they could not socialize together. With Self Determination, she found 2 workers she really liked (a friend, and the niece of this friend) and she now gets daily care, when she wants and needs it. They also take her places she wants to go (movies, out to dinner, shopping) in her community. She notes she feels her workers are like "family".

DM- is a 66 year old male in very frail health. (Spouse is Representative.) His son provides his care while the spouse works 4 nights per week. The son had to go through an agency to be paid and was making $6.76 per hour for his father's total care needs. DM wanted his son to be compensated appropriately for the work he was doing and enrolled in the Self Determination program. DM notes he feels better about the wage his son is paid to provide his care, and this in turn, reduces the "burdening feeling" he has about his son providing care for him.

BU – BU is 29 year old developmentally disabled male with a rare medical condition that requires a very specific eating regime. His mother is his representative. It was very difficult to train ever changing workers and BU's representative (his mom) also works full time. She was becoming very depressed and agitated about the constant changes and difficulties with maintaining regular workers. She had a long time family friend, an RN, who just wanted to work part time and she agreed to be hired for BU's care. BU's Mom also interviewed another individual referred to her and she hired her as well. This has provided BU and his Mom with a regular schedule of care giving that has provided consistency with his dietary needs with people they both trust.

EH – EH is a 93 year old female, who has late stage Alzheimer's and requires 24 hour care. Edith's daughter (who is her rep.) was private paying 2 workers to cover her work schedule. She was running out of money and was going to have to place her mother in a nursing home. She contacted Burnham Brook and her mother qualified for the MI Choice WA program. At the time of assessment, the daughter decided on the Self Determination option, as her mother was very comfortable with the 2 workers she has had in her home for over a year. The daughter figures her mother will be able to remain in her home indefinitely.

September 2007

Overview
LTC Insurance Partnership Program

September 2007

Through the LTC Insurance Partnership program, states promote the purchase of private LTC insurance by offering consumers access to Medicaid under special eligibility rules, should additional coverage (beyond what the policy provides) be needed. Medicaid, in turn, benefits by having individuals take responsibility for the initial phase of their long-term care through the use of private insurance.

Section 6021 of the Deficit Reduction Act of 2005:

- Allows states to develop long-term care insurance partnership programs, in collaboration with private insurers, to create affordable insurance products that protect and benefit both the consumer and state Medicaid programs.

- Includes consumer protections such as the provisions of the National Association of Insurance Commissioner's Model LTC regulations http://www.naic.org/documents/committees_models_ltc.doc

- Requires that policies sold to those under age 61 provide compound annual inflation protection. Requires that policies include some type of inflation protection when purchased by a person between the ages of 61 and 76. For those policies sold to person over the age of 76, there may be some inflation protection.

- Requires a dollar for dollar disregard of assets equal to the amount of qualified long-term care insurance coverage that an individual exhausts.

- Requires a State Plan amendment to be submitted to CMS by October 7, 2007.

- Requires HHS to establish a National Clearinghouse for LTC Information that will educate consumers about LTC insurance. www.longtermcare.gov

- Includes training criteria for insurance agents.

Michigan Public Act 674 of 2006:

- Requires the Michigan Departments of Community Health and Human Services, and the Insurance Commissioner's Office, to establish a long-term care partnership program for the financing of long-term care in Michigan through a combination of public and private funding.

- Requires a dollar-for-dollar disregard.

Other Issues

- Coordination with multiple stakeholders
- Target population and state budget impact
- Consumer and agent education
- Inflation protection
- Reciprocity between states

Several steps needs to be taken before this policy is implemented"

- A Medicaid State Plan amendment must be submitted to CMS requesting permission to implement the partnership with Michigan's Medicaid program. PA 674 of 2006 requires that the state submit this plan by October 7, 2007. Final wording is being worked out among the state agencies. The State Plan language deals with the Medicaid eligibility determination for Partnership policy holders.

- The State must establish a set of criteria that will define a "qualified long term care plan." Most of these must parallel what the state already has as existing requirements for LTC insurance policies. Exceptions include the DRA requirement that there be inflationary protection built-in to Partnership policies, and a requirement that insurance agents selling LTC Partnership-qualified policies receive a certain amount of training.

- The Office of Financial and Insurance Services (OFIS) will certify which individual plans meet the qualifying criteria.

- The Departments of Community Health and Human Services, and the Insurance Commissioners Office must execute a Memorandum of Understanding detailing about each department's role and responsibilities.

- Training for individuals who sell qualified LTC insurance policies to ensure awareness of the target population and consumer protections.

- Marketing and education to consumers.

- Eligibility policy must be revised to address asset and estate recovery disregards in amounts equal to the benefits paid under a qualified LTC policy

Progress to Date:

A state project team comprised of over two dozen members representing state governments, the insurance industry, consumer advocacy organizations and consumers, is meeting monthly to identify, clarify, discuss and reach consensus on resolving the issues surrounding the LTC Insurance Partnership. The following workgroups will be created to move the project forward:

- Data Collection
- Consumer Education
- Producer (Agent) Education
- Marketing and Outreach
- Legislative & Regulatory Issues
- Estate Recovery - Legislative & Regulatory Issues

Intent remains to have LTC Insurance Partnership products available for sale on July 1, 2008.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

AUG 2 4 2007

Paul Reinhart, Medicaid Director
Medical Services Administration
Michigan Department of Community Health
400 South Pine Street
P.O. Box 30479
Lansing, Michigan 48933-7979

Dear Mr. Reinhart:

I am writing to follow up on my letter to you on May 11, 2007 and your August 7, 2007 conversation with Jackie Garner, Medicaid Consortium Administrator, and Verlon Johnson, Medicaid Associate Regional Administrator for the Chicago Regional Office, on the status of Michigan's compliance with federal estate recovery requirements. Jackie and Verlon also informed you that Michigan's failure to comply with the Medicaid estate recovery law places the State at risk for loss of future federal Medicaid payments.

Congress enacted the Medicaid estate recovery law with the effective date of this requirement under sections 1902(a) (18) and 1917(b) of the Social Security Act of October 1, 1993. States that required legislative action were given until December 31, 1994 to implement the law. CMS staff have regularly and consistently offered technical assistance to Michigan since the estate recovery law was enacted in an effort to bring the state into compliance. Michigan is now the only state remaining that has not implemented an estate recovery program.

It is our understanding that the Michigan legislature has several bills on estate recovery under review but to date no bills have been passed. Because Michigan has not implemented an estate recovery program required by Sections 1902 (a)(18) and Section 1917 (b) of the Social Security Act, we are prepared to recommend to the Administrator that he promptly initiate a compliance action under Section 1904 of the Act to withhold federal Medicaid payments to Michigan. However, we will not recommend that the Administrator initiate a compliance action if the State enacts necessary legislation to implement an estate recovery program by September 30, 2007. Please note that even if such legislation is enacted, continued avoidance of a compliance action under Section 1904 will depend on prompt implementation of an estate recovery program by the State Medicaid agency consistent with State administrative rule making requirements.

I request that the State communicate the status of your estate recovery legislation and any actions you will be taking to implement an estate recovery program to the Chicago Regional Office by October 1, 2007. The Chicago CMS staff are available to provide you with any additional technical assistance you may need. If there are any questions, you may contact Verlon Johnson at (312) 886-5343.

Sincerely,

Dennis G. Smith
Director

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

September 5, 2007

The Honorable Jason Allen
Michigan Senate
820 Farnum Building
P.O. Box 30036
Lansing, Michigan 48909

Dear Senator Allen:

As I stated in a letter to you dated June 19, 2007, Michigan faces severe consequences should the state Medicaid program not comply with the federal estate recovery law. By not enacting estate recovery legislation, the state Medicaid program is in jeopardy of having payments withheld by the federal government – **a loss of over $5 billion annually**.

Under Title XIX of the Social Security Act, the state Medicaid program is required to implement an estate recovery program. Michigan has been non-compliant and remains to be the only state in the nation to not have implemented an estate recovery program. As I mentioned in my previous letter, Michigan was subject to a compliance meeting convened by the Centers for Medicare and Medicaid Services (CMS). In the attached letter received on August 24 from Dennis G. Smith, Director of the Centers for Medicaid and State Operations, to state Medicaid Director Paul Reinhart, it was made clear that CMS is prepared to recommend prompt action to withhold Medicaid payments to Michigan. The state has been given the deadline of September 30, 2007, to bring the state into compliance.

On October 1, 1993, the Congress passed Medicaid estate recovery laws on the basis that some of the unspent resources no longer needed by people who are deceased, and who have had the benefit of Medicaid services, should be recovered. Primarily, the program would seek repayment from nursing home and community-based waiver services. Recovery is made when a recipient and the recipient's dependents no longer need those assets. The money recovered is returned to the Medicaid program and is used to pay for care of other Medicaid beneficiaries. At a minimum, states must recover from assets that pass through probate.

Again, I strongly urge passage of **Senate Bill 374**, legislation introduced during this session to create and implement the Medicaid estate recovery program and bring Michigan in line with all of the other states under the law. Senate Bill 374 was referred from Senate Appropriations Committee on April 4, 2007, but has not yet received any further action at this time. Time is now of the essence and action by the Legislature is critical in maintaining the supports and services provided by the state Medicaid program. As stated in the accompanying letter from CMS, they will not recommend that the Administrator initiate a compliance action if the state enacts necessary legislation to implement an estate recovery program by September 30.

I hope you take action on this matter promptly. I encourage you to contact our Legislative Liaison, Curtis Hertel, Jr., at (517) 241-1939 if you wish to meet or speak with him regarding the details of the estate recovery program in greater detail.

Sincerely,

Janet Olszewski

Janet Olszewski
Director

Attachment

Long-Term Care Commission Members List

CHAIRPERSON

Farmer, Andrew, Associate State Director
AARP/Michigan
309 North Washington Square, Suite 110
Lansing, Michigan 48933
Phone: 517.267.8921
Fax: 517.482.2794
Email: afarmer@aarp.org
Membership Information: Represents primary or secondary consumers of long-term care supports and services. Term expires December 31, 2009.

Allison, Robert
Service Employees International Union
220 Bagley, Suite 1020
Detroit, Michigan 48226
Phone: 313.963.3847
Fax: 313.963.4642
Email: bob.allison@seiuhealthcaremi.org
Membership Information: Represents direct care staff providing long-term care supports and services. Term expires December 31, 2010.

Chaney, RoAnne, Health Policy Coordinator
Michigan Disability Rights Coalition
780 West Lake Lansing Road, Suite 200
East Lansing, Michigan 48823
Phone: 517.333.2477 x319
Fax: 517.333.2677
Email: roanne@prosynergy.org
Membership Information: Represents primary or secondary consumers of long-term care supports and services. Term expires December 31, 2010.

Chesny, Christine, President
MidMichigan Visiting Nurses Association
3007 North Saginaw
Midland, Michigan 48640
Phone: 989.633.1401
Fax: 989.633.1412
Email: chris.chesny@Midmichigan.org
Membership Information: Represents providers of Medicaid funded long-term care supports and services. Term expires December 31, 2008.

Long-Term Care Commission Members List

Ewing, Linda, Economist
United Auto Workers
8000 East Jefferson
Detroit, Michigan 48214
Phone: 313.926.5849
Fax: 313.881.7161
Email: lewing@uaw.net
Membership Information: Represents primary or secondary consumers of long-term care supports and services. Term expires December 31, 2008.

Fuller, Connie, **Advisor**
14081 Evergreen Road, PO Box 61
Rock, Michigan 49880
Phone: 906.356.6381
Email: cfuller1967@talkamerica.net
Membership Information: Represents primary or secondary consumers of long-term care supports and services. Term expires December 31, 2008.

Gutos, William, **Advisor**
6075 North Gatehouse Dr. SE
Grand Rapids, Michigan 49546
Phone: 616.949.6772
Fax: 616.949.1714
Email: bgutos@comcast.net
Membership Information: Represents primary and secondary consumers long-term Care supports and services. Term expires December 31, 2009.

Hoyle, Dohn, Executive Director
Arc Michigan
1325 South Washington Avenue
Lansing, Michigan 48910
Phone: 517.487.5426
Fax: 517.487.0303
Email: dhoyle@arcmi.org
Membership Information: Represents primary and secondary consumers of long-term care supports and services. Term expires December 31, 2008.

Kilde, Sandra, **Advisor**
6726 South Washington, Lot 26
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Email: sjkhh2@hughes.net
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Long-Term Care Commission Members List

Mania, William, **Advisor**
Franklin Terrace
26962 Franklin Road, Apt. 205
Southfield, Michigan 48034
Phone: 248.420.3087
Email: wild_bill_dead@yahoo.com
Membership Information: Represents primary and secondary consumers of long-term care supports and services. Term expires December 31, 2007.

McKinney, Yolanda, CEO and Executive Director
Caring Hearts Home Care
15565 Northland Drive, Suite 406W
Southfield, Michigan 48075
Phone: 248.483.3840
Fax: 248.493.3850
Email: yb406@aol.com
Membership Information: Represents providers of long-term care supports and services. Term Expires December 31, 2007.

Moers, Marsha, Community Advocacy Coordinator
Disability Network
1048 Pierpont, Suite 9/10
Lansing, Michigan 48911
Phone: 517.241.0393
Fax: 517.241.0438
Email: mmoers@cacil.org
Membership Information: Represents primary or secondary consumers of long-term care supports and services. Term expiring December 31, 2010.

Rabidoux, Denise, Chief Executive Officer
Evangelical Homes of Michigan
18000 Coyle Avenue
Detroit, Michigan 48235
Phone: 313.836.5906
Fax: 313.836.5641
Email: rabidouxd@evangelicalhomes.org
Membership Information: Represents direct care staff providing long-term cares supports and services. Term expires December 31, 2008.

Long-Term Care Commission Members List

Reardon, Jon, Administrator
Hoyt Nursing and Rehabilitation Center
1202 Weiss
Saginaw, Michigan 48602
Phone: 989.754.1419
Fax: 989.754.4805
Email: hoyt22@speednetllc.com
Membership Information: Represents providers of long-term care supports and services. Term expires December 31, 2010.

Turnham, Hollis, Michigan Policy Director
Paraprofessional Healthcare Institute
5013 Applewood Drive
Lansing, Michigan 48917
Phone: 517.327.0331 voice
Fax: 517.327.0331
Email: Hollis@paraprofessional.org
Membership Information: Represents direct care staff providing long-term care supports and services. Term expires December 31, 2007.

Williams II, Reverend, Charles, **Advisor**
220 Bagley, Suite 524
Detroit, Michigan 48226
Phone: 313.344.9014
Email: cwilliams@IM4Justice.com
Membership Information: Represents primary and secondary consumers of long-term care supports and services. Term expires December 31, 2007.

Wilson, Toni, Long-Term Care Ombudsman
Citizens for Better Care
4750 Woodward Avenue, Suite 410
Detroit, Michigan 48201
Phone: 313.832.6387
Fax: 313.832.7407
Email: twilson@cbcmi.org
Membership Information: Represents primary and secondary consumers of long-term care supports and services. Term expires December 31, 2007.

Long-Term Care Commission Ex-Officio and Support Contact List

Special Advisor

Ablan, Mary, Executive Director
Area Agency on Aging Association of Michigan
6105 West St. Joseph, Suite 204
Lansing, Michigan 48917
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Fax: 517.886.1305
Email: ablan@iserv.net

Ex-Officio Members

Head, Mike, Director, OLTCSS
(for Janet Olszewski, Director, DCH)
Michigan Department of Community Health
Office of Long-Term Care Supports and Services
Washington Square Building, 7th Floor
109 Michigan Avenue,
Lansing, Michigan 48913

Phone: 517.335.0276
Fax: 517.241.2345
Email: HEAD@michigan.gov

Enright, Vicki
(for Keith W. Cooley, Director, DLEG)
Department of Labor and Economic Growth
Bureau of Workforce Programs
Victor Office Center
201 North Washington Square, 5th Floor
Lansing, Michigan 48913

Phone: 517.335.5858
Email: enrightv@michigan.gov

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Office of Services to the Aging
7109 West Saginaw, PO Box 30676
Lansing, Michigan 48909-8176

Phone: 517.373.8268
Fax: 517.373.4092
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Slocum, Sarah
Long-Term Care Ombudsman
7109 West Saginaw, PO Box 30676
Lansing, Michigan 48917

Phone: 517.335.0148
Fax: 517.373.4092
Email: SlocumS@michigan.gov

Mussen, Donald C.
(for Ismael Ahmed, Director, DHS)
Director of Adult and Family Services
Department of Human Services
235 South Grand Avenue, PO Box 30037
Lansing, Michigan 48909

Phone: 517.335.4323
Email: MussenD@michigan.gov

MICHIGAN LONG-TERM CARE SUPPORTS & SERVICES ADVISORY COMMISSION

OPERATIONAL GUIDELINES

Adopted
March 26, 2007

TABLE OF CONTENTS

Broad Priorities, Agenda Setting & Planning

1. The Executive Order establishing the Commission and the Office has the implementation of the 2005 Governor's Medicaid Long Term Care Task Force Recommendations as central to their common Charge, so it these Recommendations which frame and guide all Commission priorities, agendas and planning.

2. Whereas the strength of the Task Force Recommendations, in both depth, integration and unanimous support stemmed directly from a statewide, widely-inclusive process of stakeholders, branches of State Government and the public, the Commission should endeavor to conduct its work in a manner consonant with the Task Force process model.

3. The Commission's engagement of statewide, widely inclusive groups of stakeholders, branches of State Government and the public should seek the consolidation of other public work in progress.

4. The Commission will establish workgroups and seek involvement from stakeholders, branches of State Government, the public, and the Commission.

5. These workgroups will scan the environment for both public and private work in progress that supports the actualization of the Task Force Report.

6. The workgroups will work in concert with the Office to develop strategies and advice for the use of public and private resources to address the needs and opportunities to do so.

7. The above process and its evolving structure serves as the Commission's primary policy, priority-setting and planning resource within the Task Force Recommendations; they function as the Commission's superstructure for ongoing public participation and communications in statewide education and planning.

8. Issues brought to the Commission's attention outside of this structure, whether brought by the Office, the Legislature, Public Comment, state or national events or the media should be reviewed by Commissioners and the Office (possibly Executive Committee members, if between meetings) for alignment with Task Force Recommendations; then if applicable referred to workgroups or other public individuals or bodies for development of a Commission response within its established priorities or recommend action through the reordering of priorities.

9. Planning cycles will be established and maintained for and between the Office and the Commission, and, between the Commission and what workgroups or other ongoing initiatives it undertakes. Plans for all these entities will address each of the Recommendations but may prioritize among them from year to year across the entities and subgroups so as to maximize the policy development and advocacy.

Meeting Protocols & Management

1. Commission meetings shall benchmark progress toward goals and objectives of the Commission, and the Office, for the full implementation of the Task Force Recommendations. Commissioners and Office staff ought to be able to cite activities which serve and further such implementation at the end of each meeting – and name next steps and agenda for the next meeting to assure the Commission's work remains on track.

2. Annual plans will map milestones of accomplishment across the yearly calendar of meetings to assure success and frame the agendas and outcomes of each meeting.

3. Annual plans will be shared with the Commission, its workgroups and the public as dynamic documents, having flexibility for adjustment of timetables according to progress or lack thereof. Revised timetables will be determined by the full Commission, either at meetings through its agenda or between meetings using the Executive Committee and/or e-mail to complete the work for distribution to workgroups and the public.

4. Annual Plans and agendas of full Commission meetings and workgroups shall be publicly posted and available at least one week before meetings, two weeks ahead is optimal Background materials supplied to the Commission should also be posted and publicly available.

    a. Agendas will be developed by the Chair with assistance from the Executive Committee and designated Office staff.

b. Minutes will be approved by the Chair with assistance from staff designated by the Office with assistance from the Executive Committee before being issued for full Commission Review and Approval.

c. Fully Approved Commission Minutes will be publicly posted within 14 days after each Commission meeting.

5. Staffing support and assistance from the Office to the Commission will be in accordance with the Executive Order and with the Office Memorandum dated February 26, 2007 issued to the Commission at its Retreat gathering the same day. The Office Memorandum designates Gloria Lanum of the OLTCSS as the staff person Commissioners address questions and other needs related to Commission business and issues.

6. All Commissioners agree to review agendas, draft minutes and supporting materials before meetings to foster their active participation in discussions and decision-making.

7. Executive Committee meetings are convened at the pleasure of the Chair.

8. Commission members and workgroup volunteers will be encouraged to make donations of their personal, community and organizational resources at their disposal to enhance and leverage Commission and Office activities which enhance facilitation of the broader work. Such donations may include and are not limited to additional staffing, material, logistical support and coordination, meeting facilities, personal supports assistance and communications.

9. Annual planning by all Commission-related entities will target such logistical needs as part of operationalizing and

sustaining their work. Office staff and the Commission Executive Committee will inventory these resource capacities, advertise specifically identified donation opportunities to the public; the Commission may delegate management of these logistics and their coordination to a special committee.

10. When the Commission or its Chair creates workgroups or committees, those workgroups or committees will receive a specific written charge of its role and responsibilities, membership, with established deadlines for completion and submission to the full Commission for consideration. Findings or recommendations from workgroups or committees are not those of the Commission or the Chair.

    a. The ability of the Office to staff and support workgroups and committees is likely to be limited and will be determined by the Chair and the Office Director.

    b. Meeting protocols for workgroups and committees will follow Commission protocols as closely as possible.

    c. Effective communications between and among the Commission and its committees and workgroups will be sought.

11. Commission members must be present, physically or electronically, to vote. Commission members who are unable to be present may have a representative attend meetings to observe and listen to proceedings.

12. Commission meetings will always include at least one time period for public comment. The Chair will manage that section of the agenda to encourage public input on all long-

term care issues and to complete Commission business. (See Operational Guideline for Public Comment, page 6.)

13. Commission meetings will include input from the Office.

14. Commission decision-making processes are guided by the adopted "Consensus Defined" document (reprinted in full below). Any Commissioner who "blocks" a decision is obligated to explain his/her reasons for blocking Commission action at the time of voting. That same Commissioner is also obligated to work with the Chair or his/her designee to remove the "block" at the next Commission meeting.

Consensus Defined

Excerpted from *True Consensus, False Consensus* by Bea Briggs, published in the Journal of Cooperative Living, Winter, 2001

The consensus process is a decision-making method based on values such as cooperation, trust, honesty, creativity, equality, and respect. Consensus goes beyond majority rule. It replaces traditional styles of top-down leadership with a model of shared power and responsibility.

The consensus process rests on the fundamental belief that each person/organization has a piece of the truth. Each member of the group must be listened to with respect. On the other hand, individuals/organizations cannot be permitted to dominate the group.

This is not to suggest that the consensus process presupposes or automatically confers complete peace and harmony within a group. In fact, in groups that are truly diverse, differences are both a sign of health and an invitation to creativity.

Consensus is not a panacea. It will not work in every situation. In order to invoke the power and magic of consensus, these main elements must be in place:

- Willingness to share power
- Informed commitment to the consensus process
- Common purpose
- Strong agendas
- Effective facilitation.

Procedure for Determining Consensus

In the consensus process, no votes are taken. Ideas or proposals are introduced, discussed, and eventually arrive at the point of decision. In making a decision, a participant in a consensus group has three options.

- To give consent. When everyone in the group (except those standing aside), says "yes" to a proposal, consensus is achieved. To give one's consent does not necessarily mean that one loves every aspect of the proposal, but it does mean that one is willing to support the decision and stand in solidarity with the group, despite one's disagreements.

- To stand aside. An individual stands aside when he or she cannot personally support a proposal, but feels it would be all right for the rest of the group to adopt it. Standing aside is a stance of principled non-participation, which absolves the individual from any responsibility for implementing the decision in question. Stand asides are recorded in the minutes of the meeting. If there are more than a few stand-asides on an issue, consensus has not been reached.

- To block. This step prevents the decision from going forward, at least for the time being. Blocking is a serious matter, to be

done only when one truly believes that the pending proposal, if adopted, would violate the morals, ethics, or safety of the whole group. One probably has a lifetime limit of three to four blocks, so this right should be exercised with great care. If you frequently find yourself wanting to block, you may be in the wrong group.

Consensus decisions can only be changed by reaching another consensus.

Setting & Maintaining
Short Term Public Policy Priorities

1. The Task Force Final Report Recommendations and their source material in the Task Force's Full Workgroup Reports, taken together, establish the ongoing framing through which current public issues are scrutinized for their relative importance and their sequencing for Commission attention and action.

2. Public issues can be named and brought to the attention of the Commission by anyone at anytime and conveyed by any means; if by the public, as part of Public Comment and/or Commission-related workgroups and other activities.

3. Public issues receive Commission priority from Commission deliberation and action, based primarily on:

   - Whether attention and action on the issue by the Commission addresses implementation of one or more Task Force Recommendations.

   - Commission decisions about priorities and actions should be based on which of those leverage a greater number of Recommendations' implementation; the greater number of Recommendations that are advanced – or impeded – by the issue, the greater priority that Issue should receive.

   - Additional scanning of public issues for their potential Commission priority should factor in the following measures:

     ✓ which are most achievable

- ✓ which make the biggest impact (affect more people, longer lasting)
- ✓ which have the most positive outcome
- ✓ even if relatively unimportant, which simply cannot wait
- ✓ which are totally obvious, regardless of subjectivity or objectivity
- ✓ those not being addressed elsewhere or receive little ongoing attention
- ✓ those on which there is higher awareness and support
- ✓ sustainable resources are available to tackle it
- ✓ gut instinct or intuition ~ "it just feels right"

4. Issues selected in this way for Commission Priority may be sequenced and staggered across monthly agendas and interim activities based on success rates, outcomes and available Office and Commission resources.

5. The sequencing and staggering of Issues evolves into a longer range Commission Agenda and provides further basis for public advocacy planning and activities.

6. Establishment of Commission workgroups and other initiatives expands the number of priorities the Commission can adopt and the potential resources available to sustain such work and advocacy.

Commission Responses to Public Comment

1. The Office of Long Term Care Supports & Services will provide, maintain and publicize contact mailing information for the public to send correspondence they wish addressed directly to the attention of Commission.

2. Any Commission member may receive public comment from any person in any form the person chooses, whether verbally, hand-written, typed, emailed or left in voicemail at any time in a given month and at Commission meetings, other public activities and other functions of Commission-related public committees, workgroups and presentations. Comments received by Commissioners between meetings should be forwarded to the Commission Secretary and the Chair; if received in writing, the recipient Commissioner should forward copies to the Commission Secretary and Chair, retaining the original until a formal written response has been mailed to the commenter.

3. Comments received between Commissions meetings will be reported by the Secretary (or in their absence, his or her Commission designee) as part of Public Comment at ensuing full Commission meetings.

4. The Public Comment portion of Commission agendas will include Commissioner questions of commenters present and Commission deliberation as needed and desired by Commissioners and Office staff.

5. Following Commission meeting adjournment, the Commission will respond promptly in writing to each comment received; the responsibility will fall primarily to the Commission Chair; he or she may ask a Commissioner, with experience and/or expertise particularly pertinent to

the comment received, to draft a response and even voluntarily sign the given response on behalf of the Commission. Copies of comments and responses will be kept on file by the Commission Secretary, with support and assistance from Office staff.

6. Written Commission responses to public comment should include as many of the following ingredients as pertinent and possible:

   - A brief recapitulation of the issues raised by the commenter.

   - A brief recapitulation of Commission questions, discussion and verbal reactions, if any.

   - A scan of federal and state laws, regulatory systems, programs and resources, including private resources, which are or might be pertinent to the issues raised and possibly appropriate to also respond; this should stem from Commission discussion wherein the Commission may choose to refer the commenter or, at the Commission's choosing, seek permission from the commenter to make related referrals of their comment as part of a Commission inquiry to the given agency(ies) or program(s); in the latter situation the Commission shares the third party's written response with the commenter while deliberating and deciding whether the agency response indicates needs for Commission advocacy action and/or policy development.

   - Every written Commission response ought end with advocacy action steps and discussion of further opportunities for commenters to become involved or increase their involvement in organizing in their

communities and building broad movements for further reform of long term care, especially those with the greatest pertinence to their issues and their systemic, backdrop causes.

- Each Commission written and verbal response conveys the utmost respect and deep appreciation for every commenter's efforts – sometimes at great personal cost and even risk – to make their voice heard.

7. A brief report and analysis of total public comment received by the Commission will be prepared each year by a subcommittee of Commissioners and Office staff as part of the annual report; other than issues, the summary should also include geographical and whatever known demographic characteristics of commenters as a group, and, possible learnings for improving the breadth, depth and public accessibility to participate in comment to the Commission.

Single Point Entry Demonstration Evaluation and Monitoring

1. Commissioners shall proactively assure their own learning needs and understanding of Task Force Recommendations, Executive Order Charges, the ensuing Request for Proposals process, State Law, local needs and developments relative to Single Point Entry and Demonstrations are addressed on an ongoing basis.

2. New Commissioners shall specifically request that the Office orient them to the specifics of each Demonstration Contract executed. The orientation will include but not be limited to apprising Commissioners of important distinctions and variances between the respective Demonstration Contracts and resulting individual contract expectations of the Office of each respective Demonstration Contractor. Updates shall be provided to all Commissioners if/when specific contracts are modified and/or Office expectations change on specific contractors. For the purposes of 2007, all Commissioners shall consider themselves and be regarded as new Commissioners.

3. At least twice each year the Commission shall request of the Office status updates on each of the Demonstration Contractor's contract compliance and activities. The status updates shall include but not be limited to:

   - Basic data on client (consumer, callers, etc.) profiles.
   - Numbers of clients being served.
   - SPE Service Delivery Staffing.
   - Client outcomes.

- Public Education, Marketing and Outreach Plans, Activities (including events, products, tools and other deliverables).

- Governing Boards' and Consumer Advisory Board composition, status and activities.

- Legal and financial status.

- Community Needs Assessment tracking activities; detail on populations, unmet needs, unmet preferences and stakeholder capacity analyses on the local provider array.

- Internal Contractor-specific quality improvement targeting and performance-tracking.

4. Commissioners may receive from any party, including SPE Demonstration Contractors, reports on SPE Demonstration activities directly to the Commission as part of Commission processes and opportunities for Public input and Comment.

5. Direct Commissioner SPE Demonstration site visitation shall be facilitated at least once yearly by the Chair and the Office; the more Commissioners visiting more sites the better; Commissioner site visitation should attempt, as a minimum, direct contact with consumers using SPE services, as confidentially authorized by the given consumers; the use and release of specific consumer information gained by Commissioners by such contacts, if any, shall be defined, determined and authorization denied or withdrawn at the pleasure of each specific consumer at ant time; as a rule, the purpose of such Commissioner-consumer contact is not to seek such personal information but to build and maintain each Commissioner's own

sensitivity and awareness of consumer experience on thematic and systemic levels.

6. The above Guidelines establish a floor of discernment for each Commissioner evaluate Task Force Recommendation on Single Point Entry and their implementation between and among each of the following: The Executive Order, the State Law, Demonstration Contractors' the Office's and Commission positions, actions and activity on record.

7. The primary Commissioner aids to this discernment are:

   A. The Full Task Force Workgroup "A" Report document on Single Point Entry.

   B. The full performance evaluation tool, process and document adopted by the Office following the Commission's recommendation for this.

   C. What Commission workgroup(s) may be focusing on SPEs and the service capacities of the provider array.

   D. Emerging Commission and public deliberations, plus local, state and national developments regarding SPEs and long term care reform.

8. Using the above, process of discernment of SPE evaluation and advocacy, the Commission's continuing recommendations in these areas should draw from at least two primary concerns:

   - redressing what distances exist and are growing, if any, between the original Task Force Recommendations for Single Point Entry versus what actually is being implemented at the State and local levels

- what areas and operational issues of SPEs are not adequately addressed to begin with by the Task Force Recommendation, and Full Workgroup Report on SPE itself.

APPENDIX A WORKGROUP CHARGES

WORKGROUP ON FINANCE REFORM
Charge to Workgroup

- Review and monitor the implementation of recommendation # 9 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the access to quality long-term care and supports through efficient long-term care finance reform.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would adapt financing structures that maximize resources, promote consumer incentives and decrease fraud.
- Ensure all recommendations:
  - Involve consumers and broad public participation in planning.
  - Promote an array of long-term care services and supports.
  - Promote the concept of money (funding) following the person to wherever that person chooses to live.
  - Assure evaluation is addressed.
  - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.

Strategies / Action Steps

1. Michigan should decouple its estate tax from the federal estate tax to make more revenue available.
2. Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports.

3. The Michigan Congressional Delegation should:
   a. Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance.
   b. Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid.
   c. Urge the Congress to revise the current Federal Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application.
4. Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program.
5. Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers.
6. Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of the Long-Term Care Insurance Partnership Programs.; b) expand the state employees' self-funded, long-term care insurance program; and c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance.
7. Tax credits and tax deductions for the purchase of long-term care insurance policies and for "out of pocket costs" for LTC should be considered.
8. A "special tax exemption" for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a $1,800 exemption proposed in legislation

introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less than $1 million.

As an initial step, Michigan should adopt a Case-Mix reimbursement system to fund LTC services and supports. This approach sets provider rates according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted.

9. Michigan should encourage and strengthen local and regional programs that support caregivers in their care giving efforts.
10. An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation.
11. There should be ongoing review and strengthening, along with strict and consistent enforcement, of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility.
12. There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable individuals.
13. State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care.
14. New legislation for the regulation by the state of "trust mills" and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulations, registration of out-of-state companies, and prescreening of sales materials.
15. Appropriate state agencies should analyze and quantify the relationship between public and private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars.
16. The state should study and pursue aggressive Medicare recovery efforts.
17. Medicaid eligibility policies should be amended to:

a. Permit use of patient pay amounts for past medical bills, including past nursing facility bills.
b. Require full certification of all Medicaid nursing facilities.
c. Require dual certification of all nursing facilities.

18. The task force recommends full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be $4.3 million. Of the increase, $2 million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; $2.3 million would go to the external advocacy organization outlined in Section 8 of the Model Act.

Benchmarks

1. Increased state and federal support will be available to implement Person-Centered Plans and consumer choice options.
2. A reduction of inappropriate asset and income sheltering will be achieved.
3. Improved federal-state funding partnership will be achieved.
4. An increase in the number of Michigan citizens with LTC insurance will be achieved.
5. An adequate allocation of finances and resources across the array of supports and services will reflect informed consumer choices in the delivery of LTC services and supports.

WORKGROUP ON PERSON-CENTERED PLANNING
Charge to Workgroup

- Review and monitor the implementation of recommendation # 1 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for the Person-Centered Planning process throughout the long-term care and supports system.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that will implement Person-Centered Planning across the array of long-term care and supports.
- Ensure all recommendations:
  - Involve consumers and broad public participation in planning.
  - Promote an array of long-term care services and supports.
  - Promote the concept of money (funding) following the person to wherever that person chooses to live.
  - Assure evaluation is addressed.
  - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 1: Require and Implement Person-Centered Planning Practices.

Strategies / Action Steps

The state should require and implement person-centered planning processes in statute and policy throughout the LTC system. As written in the Michigan Mental Health Code, "Person-centered planning" refers to "a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MCLA

330.1700(g). The process begins as soon as the person enters the LTC system and continues as the person seeks changes. Person-centered planning is designed to allow people to maximize choice and control in their lives. A consumer-chosen supports coordinator/facilitator located at each SPE (see below) will help the consumer navigate through a full range of services, supports, settings, and options.

Strategies / Action Steps

1. Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system.
2. Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices.
3. Require all Single Point of Entry agencies to establish and utilize person-centered planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects.
4. Include person-centered planning principles in model legislation to amend the Public Health Code.
5. Early in the implementation process, ensure the provision of training on person-centered planning to long-term care providers, regulators, advocates, and consumer.
6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system.

Benchmarks

1. Legislation requiring person-centered planning in the provision of LTC is passed in the current legislative session.
2. By January 1, 2006, the Department of Community Health, with the involvement of stakeholders, will establish in policy a person-centered planning protocol specific to LTC consumers.

3. Person-centered planning training is developed and provided to LTC providers, regulators, and advocates.
4. By October 1, 2006, each entity providing LTC services will have person-centered policies and training in place.
5. Regulatory survey and program monitoring processes are revised to include a review of the integration of person-centered planning in supports coordination activities.

WORKGROUP ON QUALITY
Charge to Workgroup

- Review and monitor the implementation of recommendation # 7 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the access to a quality long-term care and supports system.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that will advance the establishment a new quality management system for the array of long-term care services and supports.
- Ensure all recommendations:
  - Involve consumers and broad public participation in planning.
  - Promote an array of long-term care services and supports.
  - Promote the concept of money (funding) following the person to wherever that person chooses to live.
  - Assure evaluation is addressed.
  - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 7: Establish a New Quality Management System. Align regulations, reimbursement, and incentives to promote this vision of quality and move toward that alignment in all sectors of the LTC system. Ensure that the consumer is the focus of quality assurance system.

Strategies / Action Steps

1. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements.
2. Include a strong consumer advocacy component in the new system.
3. Review and analyze current performance measures (both regulatory and non-regulatory).

4. **Design performance measures that move Michigan's LTC system toward this vision of quality.**
5. **Invest quality management functions in a new Long-Term Care administration. The administration would improve quality by consolidating fragmented pieces of LTC, and defining and establishing broader accountability across the LTC array of services and supports. [Section 7 of the model Michigan Long-Term Care Consumer Choice and Quality Improvement Act in the appendix discusses some of the quality management functions in detail.]Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer.**

Benchmarks

1. Consumer determination of quality is the priority quality measure.
2. Person-centered planning is implemented throughout the LTC system.
3. Oversight of QM is established within LTC Commission and LTC administration.

WORKGROUP ON WORKFORCE DEVELOPMENT
Charge to Workgroup

- Review and monitor the implementation of recommendation # 8 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the access to a quality long-term care and supports workforce.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would encourage more effective and the high quality provision of long-term direct care, services and support.
- Ensure all recommendations:
  - Involve consumers and broad public participation in planning.
  - Promote an array of long-term care services and supports.
  - Promote the concept of money (funding) following the person to wherever that person chooses to live.
  - Assure evaluation is addressed.
  - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 8: Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices.

Strategies / Action Steps

1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers.

2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings.
3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers.
4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care.
5. Improve and increase training opportunities for direct care workers to allow for enhanced skill development and employability.
6. Increase training opportunities for employers to improve supervision and create a positive work environment.
7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record.
8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer.
9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families.
10. The Department of Human Services (DHS), Michigan Department of Community Health (MDCH), Michigan Office of Services to the Aging (OSA), Department of Labor and Economic Growth (DLEG) and other state agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports.
11. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings.

12. LTC administration will track employment trends, including turnover rates.

Benchmarks

1. Measurable increase in LTC employer use of MWA services and in LTC employer hiring of Work First participants.
2. More qualified Work First participants are recruited and successfully employed in the LTC industry, while continuing their education for entry into licensed occupations.
3. Higher compensation packages and increased training opportunities.
4. Continuously and incrementally reduced turnover rates over the next decade.
5. All people working in LTC have access to affordable health care coverage.
6. Increased use of creative management and workplace practices.
7. Use of data and consumer satisfaction to inform a system of services, state policies, and employer practices that result in consumer-driven outcomes.
8. Increased opportunities and incentives for LTC employers and their supervisory personnel to improve supervisory and leadership skills to create positive workplace environments and relationships to reduce turnover.

WORKGROUP ON PREVENTION
Charge to Workgroup

- Review and monitor the implementation of recommendation # 5 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the quality of, and access to, prevention activities particularly in the area of informal caregiver support, healthy aging, and chronic care management.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would encourage more effective provision of prevention activities particularly in the area of informal caregiver support, healthy aging, and chronic care management.
- Ensure all recommendations:
  - Involve consumers and broad public participation in planning.
  - Promote an array of long-term care services and supports.
  - Promote the concept of money (funding) following the person to wherever that person chooses to live.
  - Assure evaluation is addressed.
  - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 5: Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.

Strategies / Action Steps

Develop a DCH workgroup comprised of legislators, MSA, OSA, DHS, stakeholders / consumers, and others to oversee the collaborative process involving local public health entities engaged in prevention/chronic care. Under the direction of the DCH-led workgroup, local entities will:

1. Convene a broad-based coalition of aging, disability, and other organizations.
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).
3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.
4. Develop and support programs to address prevention, chronic care, and caregiver supports.
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.
6. Develop wrap-around protocols for caregiver/consumer support needs.
7. Develop a public health caregiver support model.
8. Create initiatives and incentives to support caregivers.
9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).
10. Create incentives for implementing culturally competent chronic care models and protocols.
11. Develop and implement chronic care protocols, including, but not limited to:
    a. medication usage.
    b. identifying abuse and neglect, caregiver burnout/frustration.
    c. caregiver safety and health.
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.
13. Investigate grant opportunities to pilot chronic care management models.

Benchmarks

1. Needs assessments are conducted and gap analysis reports are completed and reviewed.
2. Local and statewide groups complete plans to address local health and wellness gaps.
3. Executed contracts in place with local existing entities, which are broad-based (including the aging and disability community) to address gaps.
4. Completed workgroup report evaluating progress, outcomes, and identifying next steps.
5. Every local region has a program in place to train caregivers that is culturally competent to the needs and culture of the informal caregiver.
6. Consumer supports are increased and better utilized.
7. Caregiver needs screening incorporated into Medicaid-funded screening instruments.
8. Upon retrospective review, address caregiver needs.
9. Registries completed with processes in place for ongoing updates.
10. Legislative and administrative initiatives are in place and used.
11. Increase in the number of primary and LTC providers trained and adopting the best chronic care and culturally competent models.
12. Medical schools and nursing/ancillary healthcare programs expand their curricula to include chronic care.
13. Increased numbers of students graduating from schools with established chronic care curricula/programs.
14. Increased number of providers using screens and protocol-driven interventions.
15. Increased use of assistive technology as reflected in the person-centered plan.

WORKGROUP ON PUBLIC EDUCATION AND CONSUMER INVOLVEMENT
Charge to Workgroup

- Review and monitor the implementation of recommendation # 4 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving access to a quality array of long-term care, services, and supports.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that promote meaningful consumer participation and education.
- Ensure all recommendations:
  - Involve consumers and broad public participation in planning.
  - Promote an array of long-term care services and supports.
  - Promote the concept of money (funding) following the person to wherever that person chooses to live.
  - Assure evaluation is addressed.
  - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 6: Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.

Strategies / Action Steps

Create a Michigan Long-Term Care Commission to provide meaningful consumer oversight and accountability to the state's reform and rebalancing of the long-term care system.

Recommended Actions

All stakeholders will have meaningful roles in the ongoing planning, design, implementation, and oversight efforts to achieve the recommendations of the Michigan Medicaid Long-Term Care Task Force and the long-term care efforts of the state. Consumers, families, and their representatives will be the principal participants.
All stakeholders will have meaningful roles in the ongoing planning, design, implementation, and oversight efforts to achieve the recommendations of the Michigan Medicaid Long-Term Care Task Force and the long-term care efforts of the state. Consumers, families, and their representatives will be the principal participants.
Educate consumers, families, service providers, and the general population about the array of long-term care options available so that consumers can make informed choices and plan for the future.

The goals of the public awareness and education campaign are:

1. Increase awareness of the SPE agencies through uniform "branding" of local agencies throughout the state (with uniform naming and logo, a single web site, and a geo-routed toll free number).
2. Increase awareness among consumers, prospective consumers, providers, faith-based communities, other community organizations, neighbors, friends, and family members of LTC services that consumers can choose from the array of LTC supports, determine their needs through the person-centered planning process, and have the option to control and direct their supports.
3. Authorize continuing education for professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) on the role of the SPE agency, the value of the person-centered planning process, the array of long-term supports available, and options for consumers to direct and control their supports. These professionals can direct individuals to the single point of entry and support them in making informed choices and planning for their future.

4. Assure that state employees involved in any aspect of LTC are provided mandatory training on the value of the person-centered planning process, the array of LTC supports available, and options for consumers to direct and control their supports.
5. Provide an orientation to legislators and their aides and officials in the executive branch on the value of person-centered planning, the array of long-term supports available, and options for consumers to direct and control their supports.
6. Create an educational program for children K-12 to learn about career opportunities in direct care and other aspects of LTC, and the components of the new LTC system (the array of long-term care supports available, the value of the person-centered planning process, and options for consumers to direct and control their supports) so that children can share this information with their family members.

Strategies / Action Steps

1. Develop criteria for and authorize hiring of a social marketing firm to develop a marketing and public awareness campaign that includes the following components:
    a. Uniform identity including name and logo for the single point of entry agencies;
        i. Public awareness campaign that includes radio and television public service announcements, print ads, brochures, and other appropriate educational materials; and
        ii. Local media and awareness tool kit that single point of entry agencies can use to outreach to and raise awareness among all stakeholders.
2. Develop criteria for and authorize hiring of a web design firm and an expert in creating materials for the targeted populations (e.g., seniors and people with a variety of disabilities) to design an informative, user friendly web site that can serve as a single point of information regarding LTC in Michigan. This web site will maintain the look, name, and logos developed for the marketing and public awareness campaign. The web site will include comprehensive information on

LTC, have well-developed keywords and navigation capabilities, and be linked to major search engines and other relevant web sites in a way that makes them easily accessible.

3. Establish criteria for and authorize the development of curricula for education of professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) that can be included in academic programs and continuing education requirements for licensing and/or certification and will be implemented over time.
4. Establish criteria for and authorize development of a variety of training and educational materials targeted to the specific groups described above (state employees involved in long term care, legislators and their aides, and children K-12).

Benchmarks

1. Development of campaign materials including radio and television public service announcements, print ads, brochures, and other appropriate educational materials.
2. Dissemination of campaign materials:
   a. Measured by number of media placements and numbers of materials distributed.
   b. Measured by the impact as identified by consumers, family members, and professionals that interact with the Single Point of Entry agencies.
3. Development of curricula targeted to the identified professional and educational groups.
4. Implementation of curricula targeted to the identified professional and educational groups.
5. Measured by the number of individuals that complete a curriculum or other educational program.
6. Measured by the referrals to the SPE by the professionals.
7. Measured by consumer reporting of the content of the professional interaction (i.e., if and how the professional made a referral to the SPE

and whether the professional described the potential for consumer choice and control).